CENTER *for*
REPRODUCTIVE
RIGHTS

Maternal Health and COVID-19

The Center for Reproductive Rights (the Center)—an international nonprofit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception 30 years ago, the Center has advocated for the realization of women and girls' human rights on a broad range of issues, including on the right to access sexual and reproductive health services free from coercion, discrimination and violence; on the right to bodily autonomy; preventing and addressing sexual violence; and the eradication of harmful traditional practices.

We are pleased to present this submission to the Office of the United Nations High Commissioner for Human Rights to inform the follow-up report on good practices and challenges in the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity. This submission looks at the legal frameworks on sexual and reproductive health and rights (SRHR), including maternal mortality and morbidity, and their application during times of crises in order to inform best practices and clarify State obligations in the age of COVID-19 and its aftermath.

I. Introduction

The COVID-19 pandemic has inflicted severe damage on health systems around the world. Destabilizing access to and availability of health services across regions, evidence suggests a significant increase in maternal mortality and morbidity during the COVID-19 pandemic and, although not solely attributable to COVID-19, progress in many areas of SRHR achieved in the years before the pandemic has stalled.[1] Disproportionately impacting women, studies have shown that pregnant women in particular have a higher risk of severe COVID-19 disease, intensive care unit admission, and need for invasive ventilation compared with non-pregnant women.[2] Reduced access and availability—in both direct and indirect ways— stemming from COVID-19 has also disproportionately impacted women and girls and people of diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) beyond pregnancy and maternal care.[3] While recovery from the pandemic remains slow, inconsistent, and uneven across regions,[4] widespread neglect of SRHR in the recovery process necessitates a clarification of State obligations in

[1] *See generally* World Health Organization and United Nations Children's Fund, *2022 Progress Report on the Every Woman, Every Child Global Strategy for Women's, Children's, and Adolescents' Health (2030)*, 2022, https://www.who.int/publications/i?healthtopics=56e27fa8-d578-47b0-87c7-ed0bafa14b35,4d3aac05-55f9-4049-b3ab-dbbbef640f88.

[2] *Id.*, p. 33.

[3] *Id.; see also* Roni Caryn Rabin, *Global Declines in Maternal Mortality Have Stalled*, THE NEW YORK TIMES, Feb. 22, 2023, https://www.nytimes.com/2023/02/22/health/pregnancy-complications-death-who.html?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_medium=email&_hsmi=247390170&_hsenc=p2ANqtz-_MhNlYSOY8RHMGLRvirpmdP38-GabebmPFvoRc4MZ5bDkn9MLJ55kuGe68zYiR77gm0M5WYHH0fCYeHp4QbG3kv_BvhVbtI3ZsA0mGuhUx5tn-J5I&utm_content=247390170&utm_source=hs_email.

[4] *Id.*

protecting SRHR and recommendation of best practices to fulfill these obligations as both the pandemic and recovery from its unique and severe impacts continue.

Though unprecedented in its scale and challenges for the global health system, the COVID-19 pandemic has merely exposed where fault-lines have long existed— despite progress— in terms of barriers to women and girls' health and SRHR in particular. Prompting a spate of emergency measures by States, the COVID-19 pandemic led to equally unprecedented burdens in accessing sexual and reproductive health (SRH) services including restrictions on freedom of movement at the same time the pandemic overwhelmed health systems.[5] Exacerbated by freedom of movement restrictions, the COVID-19 pandemic led to an increase in reported sexual and gender-based violence— which historically increases in crisis settings[6]—which, in turn, generally leads to increased rates of unintended pregnancy, unsafe abortion, maternal death and low birthweight, miscarriage, premature labor, and sexually transmitted infections for women and girls,[7] necessitating the exact opposite of what many States have done: increased attention to and investments in SRH services.

Indeed, abuse of emergency measures have been used to justify and expand long standing efforts to restrict SRHR directly and indirectly, especially through a de-prioritization of SRH services. Pre-existing, stigmatizing, and unnecessary legal and policy barriers grew during the COVID-19 context and, in many cases, persist. Such restrictions and de-prioritization of SRHR, including on maternal mortality and morbidity, violates States' obligations to ensure essential services— the provision of which becomes even more critical during national emergencies.[8]

Bearing in mind the persistent stigmatization of SRH care and services that have led to inadequate resources and the legal and policy barriers imposed on women and girls throughout the COVID-19 pandemic— a time of near unprecedented humanitarian need— this submission pays close attention to the specific ways some States have instrumentalized COVID-19 to either attack, curtail SRHR or neglect SRH care. This submission will first look at legal obligations of States on women and girls crises, the right to health, the right to sexual and reproductive health, and ensuring access to essential health as SRH services are classified as high priority essential services.[9] The submission then looks at the use of emergency measures by some States to place various barriers— not only through medical but also sociopolitical means— in accessing SRHR and how these barriers contributed to increased maternal mortality, maternal morbidity, and other serious, life-threatening, and preventable SRH conditions. Using concrete examples, the submission will

---

[5] Report of the Working Group on discrimination against women and girls, *Women's and girls' sexual and reproductive health rights in crisis*, April 28, 2021, para. 53.
[6] UN Women, *The Shadow Pandemic: Violence against women during COVID-19*, https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19; *World Health Organization, Violence Against Women*, March 9, 2021, https://www.who.int/news-room/fact-sheets/detail/violence-against-women.
[7] Inter-Agency Working Group on Reproductive Health in Crises, *COVID-19 Pandemic Further Threatens Women and Girls Already At Risk in Fragile and Humanitarian Settings*, May 2020, p. 2 (citing CARE Global, *The Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings*, 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/Gender%20implications%20of%20COVID-19%20outbreaks%20in%20development%20and%20humanitarian%20settings%20%28Executive%20Summary%29.pdf).
[8] *See* Human Rights Committee, *General Comment No. 36: On the right to life* (Art. 6 of the International Covenant on Civil and Political Rights), U.N. Doc. CCPR/C/GC/36 (2018), para. 26 [Gen. Comment No. 36]; *see also* World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context*, 2020, p. 29 (including as essential SRH and maternal health services during the COVID-19 pandemic).
[9] World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context*, 2020, p. 29.

also outline some best practices towards ensuring universal, non-discriminatory quality SRH care, with close attention paid to women and girls and other persons of diverse SOGIESC that have been disproportionately impacted by the COVID-19 pandemic.

II. Sexual and Reproductive Health and Rights during COVID-19

The UN General Secretary stated that "human rights are key in shaping the pandemic response"[10] and stressed the need to continue delivering SRH services during the pandemic.[11] WHO issued an operational guidance note for the COVID-19 context, in which it recommended that in the case of reduction in the availability of essential sexual and reproductive health services, digital health services and self-care interventions should be prioritized, which also includes *inter alia* ensuring access to contraception and abortion.[12]

Human rights experts have also recalled states obligations[13] to provide the full range of sexual and reproductive health information and services on a non-discriminatory basis,[14] including access to contraception, quality and acceptable maternal health care, and safe and legal abortion, in line with international human rights standards.[15] Human rights experts also stressed that the states response plans and measures to COVID-19 should not further exacerbate entrenched structural inequalities and inequities,[16] adding that health emergencies often exacerbate pre-existing barriers such as social norms and gender-based discrimination, criminalization, and third-party authorization requirements.[17]

The CEDAW Committee stressed that states must ensure access to contraceptive information and services as an essential measure[18] and recalled the states their obligations to continue to provide sexual and reproductive health as essential services, including modern forms of contraception, safe abortion and post-abortion services to women and girls at all times, including though easy-to-access procedures, such as

---

[10] UNSDG, *Op cit.*
[11] United Nations, *Shared Responsibility, Global Solidarity: responding to the socio-economic impacts of COVID-19*, March 2020, https://unsdg.un.org/sites/default/files/2020-03/SG-Report-Socio-Economic-Impact-of-Covid19.pdf
[12] WHO, *Maintaining essential healthcare services: operations guidance for the COVID-19 context: interim guidance*, 1 June 2020, https://apps.who.int/iris/handle/10665/332240
[13] Human Rights Committee, *Statement on derogations from the Covenant in connection with the COVID-19 pandemic*, U.N. Doc. CCPR/C/128/2, 24 April 2020; Committee on Economic, Social and Cultural Rights, *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights*, U.N. Doc. CESCR E/C.12/2020/1 17 April 2020.
[14] Treaty Bodies Chairs' statement on COVID-19, *UN Human Rights Treaty Bodies call for human rights approach in fighting COVID-19*, 24 March 2020, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742&LangID=E
[15] CEDAW Committee, *op. cit.* ; Statement by the Working Group on discrimination against women and girls, *Responses to the COVID-19 pandemic must not discount women and girls*, 20 April 2020, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25808&LangID=E; OHCHR Factsheet, *COVID-19 and Women's Human Rights*, 15 April 2020, www.ohchr.org/Documents/Issues/Women/COVID-19_and_Womens_Human_Rights.pdf; Working Group on discrimination against women and girls, *United States: Authorities manipulating COVID-19 crisis to restrict access to abortion*, press-release 27 May 2020, statement endorsed by Danius Pūras, Special Rapporteur on the right to physical and mental health and Dubravka Šimonovic, Special Rapporteur on violence against women, its causes and consequences, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25907&LangID=E; See also: WHO, *Addressing Human Rights as Key to the COVID-19 Response*, 21 April 2020, https://apps.who.int/iris/rest/bitstreams/1275275/retrieve.
[16] Treaty Bodies Chairs' statement on COVID-19, *UN Human Rights Treaty Bodies call for human rights approach in fighting COVID-19*, 24 March 2020, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742.
[17] OHCHR Factsheet, *op. cit.*
[18] CESCR Committee, Gen. Comment No. 22, paras. 13, 28, 45, 57, 62; Human Rights Committee, Gen. Comment No. 36, at para. 8; CEDAW Committee, Gen. Recommendation No. 24, paras. 12(d), 17.

online prescriptions.[19] Therefore, guaranteeing access to contraception can mitigate short-term demands on the healthcare system that would result from unplanned pregnancy.[20]
States parties to the International Convention on Economic, Social and Cultural Rights (CESCR) are under an obligation to devote their maximum available resources to the highest attainable standard of health.[21] This standard is replicated in the Convention on the Rights of the Child (CRC), and the CEDAW Committee in its General Recommendation No. 24 implies similar obligations for State Parties.[22] Additionally, the provision of essential health services is necessary for protecting the right to life which includes, where necessary, measures to ensure access to essential services without delay.[23]

Human rights bodies have stated that SRH services are essential, and as such, must be provided during a pandemic.[24] The WHO also categorizes reproductive health as a "high priority" essential service that must be maintained throughout the COVID-19 pandemic.[25] The CESCR Committee and the CRC Committee find that SRH is a vital component of essential health services that must continue during the COVID-19 pandemic.[26] The CEDAW Committee has noted that even as resources are reallocated to respond to the

---

[19] CEDAW Committee,
[20] CESCR Committee, General Recommendation No. 22, paras. 13, 28, 45, 57, 62; Human Rights Committee, Gen. Comment No. 36, para. 8; CEDAW Committee, Gen. Recommendation No. 24, paras. 12(d), 17.
[21] CESCR, Art. 12.
[22] CRC, Art. 24; CEDAW Committee, *see generally General Recommendation No. 24, Women and Health (Art. 12)*, 1999.
[23] Human Rights Committee, *General Comment No. 36: Article 6: Right to Life*, CCPR/C/GC/36, September 3, 2019, para. 26; *see also* Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication No. 2348/2014*, CCPR/C/123/D/2348/2014, August 30, 2018, para. 11.3 (recognizing, "as a minimum, States parties have the obligation to provide access to existing health-care services that are reasonably available and accessible when lack of access to the health care would expose a person to a reasonably foreseeable risk that can result in loss of life").
[24] CESCR Committee, General Comment No. 22: *On the right to sexual and reproductive health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights),* U.N. Doc. E/C.12/GC/22, paras. 13, 43 (2016) (listing essential SRH medicines and services that should be available, including a wide range of contraceptive methods, such as condoms and emergency contraception, medicines for abortion and for post-abortion care, and medicines, including generic medicines, for the prevention and treatment of sexually transmitted infections and HIV, and reminding States they must ensure that barriers to SRH care do not "inhibit the performance of services in urgent or emergency situations"); CRC Committee, *General Comment No. 15: On the right of the child to the enjoyment of the highest attainable standard of health*, (66th Sess.), para. 40, U.N. Doc. CRC/C/GC/15, paras. 10, 37, 40, 53 (2013) (citing WHO's Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health, and reminding that 11 States have an obligation to make all essential medicines on the WHO Model Lists of Essential Medicines, "available, accessible and affordable"); CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (20th Sess., 1999), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. A/54/38/Rev.1, paras. 16, 21, 27, 29 (1999).
[25]
[26] *See, e.g.*, CEDAW Committee, Guidance Note on CEDAW and COVID-19, para. 2 (2020), https://www.ohchr.org/en/hrbodies/cedaw/pages/cedawindex.aspx ("States parties must continue to provide gender-responsive sexual and reproductive health services, including maternity care, as part of their COVID-19 response. Confidential access to sexual and reproductive health information and services such as modern forms of contraception, safe abortion and post-abortion services and full consent must be ensured to women and girls at all times, through toll-free hotlines and easy-to access procedures such as online prescriptions, if necessary free of charge. States parties should raise awareness about the particular risks of COVID-19 for pregnant women and women with pre-existing health conditions. They should provide manuals for health workers guiding strict adherence to prevention of infection, including for maternal health, during pregnancy, at-birth and the post-delivery period."]; Office of the UN High Commissioner for Human Rights (OHCHR), *Statement by the UN Working Group on discrimination against women and girls: Responses to the COVID-19 pandemic must not discount women and girls*, (2020), https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25808&Lan; OHCHR, *COVID-19 Guidance*, https://www.ohchr.org/en/covid-19/covid-19-guidance (providing that "effective responses to COVID-19 must fully consider and address the specific situations, perspectives[,]ensure that any measures taken do not directly or indirectly discriminate based on gender [,] SRH services should be seen as a life-saving priority and integral to the response including access to contraception, maternal and newborn care; treatment of STIs, safe abortion care, and effective referral pathways ,including for victims of

pandemic, it is critical that all people have access to quality maternal healthcare which includes ensuring that women and girls do not have to undertake unsafe abortions.[27] Ensuring such access requires States to remove legal and administrative barriers to abortion services, including to medical abortion. The Inter-Agency Working Group on Reproductive Health in Crises notes more specifically that essential clinical services for SRH includes, among other things, contraception, intrapartum care for all births, emergency obstetric and newborn care, post-abortion care, safe abortion care to the full extent of the law, clinical care for rape survivors, and prevention and treatment for HIV and other sexually transmitted infections.[28] The CEDAW Committee has noted that even as resources are reallocated to respond to the pandemic [COVID-19], all people must have access to quality maternal healthcare.[29]

Regional human rights bodies have also emphasized the importance of access to SRH services during the COVID-19 pandemic. The African Commission on Human and People's Rights' Special Rapporteur on the Rights of Women in Africa issued a statement urging African states to "to adopt the principle of equality in all COVID-19 related responses while providing special protection to women and girls through access to sexual and reproductive health services,"[30] and the Inter-American Commission on Human Rights issued guidance urging states to "[g]uarantee the availability and continuation of sexual and reproductive health services during the pandemic crisis."[31]

A. *Emergency Measures*

Article 4 of the ICCPR recognizes that States may need additional powers to address emergency situations. Invocation of additional powers through a declared state of emergency, however, are strictly circumscribed under IHRL to avoid abuse. Two conditions must be met before an emergency is valid under IHRL: (1) the situation must amount to a public emergency which threatens the life of the nation, and (2) the State party must have officially proclaimed a state of emergency.[32] The powers granted during a state of emergency should be the least restrictive to achieve the stated goal, have limited geographical scope, cannot sacrifice non-derogable rights and obligations, and should include a sunset or review clause ensuring a return to ordinary law once the emergency ends.[33] These elements further reflect the principles of necessity and proportionality that must buttress any emergency measure.

---

gender-based violence [, and that] [r]esources should not be diverted away from essential SRH services, which would impact the rights and lives of women and girls in particular";

[27] World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context*, 2020, p. 29.

[28] The Inter-Agency Working Group on Reproductive Health in Crises is a global coalition of civil society organizations and individuals brought together through a collaborative and consultative process engaging over 100 members from United Nations agencies. p. 7.

[29] *See generally* CEDAW Committee, *Guidance Note on CEDAW and COVID-19*, 2020, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CEDAW/STA/9156&Lang=en.

[30] Hon. Lucy Asuagbor, Special Rapporteur on the Rights of Women in Africa, *Press Release of the Special Rapporteur on the Rights of Women in Africa on violation of women 's rights during the COVID-19 Pandemic*, African Commission on Human and People's Rights (May 6, 2020) https://www.achpr.org/pressrelease/detail?id=495.

[31] Inter-American Commission on Human Rights (IACHR), *Pandemic and Human Rights in the Americas*, Res. 1/20, para. 53 (April 10, 2020), http://www.oas.org/en/iachr/decisions/pdf/Resolution-1-20-en.pdf.

[32] Human Rights Committee, *General Comment No. 29: States of Emergency (Article 4), CCPR/C/21/Rev.1/Add.11*, para. 2, Aug. 30, 2001.

[33] International Commission of Jurists, *Siracusa Principles on the Limitation and Derogation Provisions in the ICCPR,* Principle 11, 1985, https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf.

CENTER *for* REPRODUCTIVE RIGHTS

B. *Accountability Mechanisms*

At the same time States may derogate from certain civil and political rights during emergencies (and only under strict conditions), other rule of law obligations remain applicable.[34] Specifically, Article 2, paragraph 3, of the International Covenant on Civil and Political Rights (ICCPR) requires States parties to provide remedies for any violation of its provisions, and while not listed as a non-derogable provision, "it constitutes a treaty obligation inherent in the Covenant as a whole."[35] Even where a State party can adjust the practical functioning of its procedures— including that any adjustments satisfy the requirements of legality, nondiscrimination, necessity, and proportionality— governing judicial or other remedies, the State party must comply with the fundamental obligation under the ICCPR provide a remedy that is effective.[36]

Indeed, the judiciary's obligation to ensure access to justice does not erode and usually gains more importance in an emergency where lives are threatened and States increase executive power.[37] Thus, cases involving access, or lack thereof, to essential health services and violence against women must be heard during the pandemic. States parties should identify the test by which they assess whether women have access to health care on a basis of equality of men and women in order to demonstrate compliance with article 12 of the ICCPR.[38] Judiciaries should also recognize the urgency of and provide particular consideration to applications to the court for protective and other remedial measures from women and children, older persons, persons with disabilities, and other groups who face or may face increased risks during emergencies.[39]

III. COVID-19 and preventable maternal mortality and morbidity

The damage inflicted by COVID-19 on the global health system not only risks reversing the limited gains in maternal health but also worsening the state of maternal health and SRHR more broadly before those gains. Decline in service coverage caused by the disruption and diversion of resources from maternal health to COVID-19 related services in overburdened health systems have at best exacerbated and at worst been a primary cause of stalled declines in maternal mortality seen between 2000-2020, and which the WHO concludes, requires urgency in tackling.[40] The rise in maternal mortality is not limited to one or a few regions but extends across the world, including Europe and North America.[41]

The disruption and diversion of resources in maternal health care is particularly concerning given that "even a modest decline of 10% in service coverage during pregnancy and for newborns could result in an additional 28,000 maternal deaths, 168,000 newborn deaths, and millions of unintended pregnancies as family planning services face disruptions.[42] The WHO warns that such risks of adverse outcomes associated

---

[34] *See generally* Human Rights Committee, *General Comment No. 29: States of Emergency (Article 4),* CCPR/C/21/Rev.1/Add.11, Aug. 30, 2001.
[35] *Id.*, para. 14.
[36] *Id.*
[37] Matt Pollard, *The Courts and COVID-19,* INTERNATIONAL COMMISSION OF JURISTS, April 6, 2020, https://www.icj.org/wp-content/uploads/2020/04/Universal-ICJcourts-covid-Advocacy-Analysis-brief-2020-ENG.pdf.
[38] CEDAW Gen Rec. 24, para. 19.
[39] Matt Pollard, *The Courts and COVID-19,* INTERNATIONAL COMMISSION OF JURISTS, April 6, 2020, https://www.icj.org/wp-content/uploads/2020/04/Universal-ICJcourts-covid-Advocacy-Analysis-brief-2020-ENG.pdf, p. 5.
[40] World Health Organization et. al., *Trends in maternal mortality 2000 to 2020*, 2023, p. xvi, https://www.who.int/publications/i/item/9789240068759 (other UN agencies also contributed to this report).
[41] *Id.*
[42] World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context*, 2020, p. 24.

with unattended childbirth outweigh the potential risks of COVID-19 transmission at health facilities.[43] While most regions stagnated in maternal health progress during COVID-19, the situation in certain areas help illustrate the broader impact of COVID-19 on maternal health. Indeed, resource constraints combined with public health emergencies have heightened risks to human rights violations and abuses in maternal health settings.

Women experience a wide range of rights violations when seeking maternal health care. In 2014 in a statement on disrespect and abuse during facility-based childbirth, the WHO noted that "a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture," and condemned "outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay."[44]

Discrimination in these contexts is often aimed at women with intersectional identities, including those of African descent or from ethnic minorities, refugees, migrants and women of lower socioeconomic status. For example, in some settings, migrant and refugee women may be "expected to pay higher rates for services or to pay bribes" to receive care.[45] Particularly harmful restrictions and obstacles confront undocumented migrant women in Europe, as legal and policy exclusions or financial and practical barriers severely curtail these women's ability to access affordable maternal health care throughout pregnancy.[46] And in a number of central and eastern European countries, Romani women have faced ethnic segregation and racial discrimination, harassment and abuse in reproductive health care settings including obstetric care.[47]

Treaty monitoring bodies have developed strong human rights standards on women's right to maternal health care, framing this right within the rights to life, health, equality and non-discrimination, and freedom from ill-treatment. The right to maternal health care encompasses a woman's right to the full range of

---

[43] *Id.*

[44] World Health Organization (WHO) statement, *The prevention and elimination of disrespect and abuse during facility-based childbirth*, WHO/RHR/14.23 (2015). *See also,* Special Rapporteur on violence against women, its causes and consequences, *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, U.N. Doc. A/74/137 (2019).

[45] M.A. Bohren, J.P. Vogel, E.C. Hunter, et al., The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review, PLOS Medicine 12(6) (2015) at p. 10.

[46] *See, e.g.*, Center for Reproductive Rights, PERILOUS PREGNANCIES: BARRIERS IN ACCESS TO AFFORDABLE MATERNAL HEALTH CARE FOR UNDOCUMENTED MIGRANT WOMEN IN THE EUROPEAN UNION (2018), *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Perilous- Pregnancies-Health-Care-For-Undocumented-Migrant-Women-EU.pdf.

[47] *See, e.g.*, Center for Reproductive Rights & Poradňa pre občianske a ľudské práva (Center for Civil and Human Rights), VAKERAS ZORALES – SPEAKING OUT: ROMA WOMEN'S EXPERIENCES IN REPRODUCTIVE HEALTH CARE IN SLOVAKIA (2017), *available at* https://reproductiverights.org/wp-content/uploads/2021/03/GLP-SlovakiaRomaReport-Final-Print.pdf; European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 151/2017, European Committee of Social Rights; ERRC, *Romani woman harassed by racist hospital staff during childbirth wins case*, Jan. 18, 2017, http://www.errc.org/press-releases/romani-woman-harassed-by-racist-hospital-staff-during-childbirth-wins-case (last visited May 22, 2019); Carmen Gheorghe & Cristina Mocanu, *Challenging intersectionality: Roma women's voices and experiences: Experiences of discrimination of Roma women in housing, education, health and employment - Comparative research on multiple discrimination in Finland, Italy and Romania* (2021), E-Romnja Association for Promoting Roma Women's Rights, Romni Onlus, Helsinki Deaconess Institute Foundation, Center for Not-for-profit Law, http://e-romnja.ro/wp-content/uploads/2021/04/Research-Intersect-Voices-.pdf.

services in connection with pregnancy and the postnatal period and the ability to access these services free from discrimination, coercion, and violence.[48] In General Recommendation No. 24, the CEDAW Committee recommended that states "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[49]

States must guarantee all women available, accessible, acceptable, and good quality maternal health services.[50] Treaty monitoring bodies have further found that social and other determinants of health must be addressed in order for women to be able to seek and access the maternal health services they need.[51] In General Comment No. 36, the Human Rights Committee affirmed that preventable maternal deaths are a violation of the right to life and recommended that states develop strategic plans and campaigns for improving access to treatments designed to reduce maternal mortality, as part of advancing the enjoyment of the right to life.[52] Treaty monitoring bodies have also specifically recognized that intersectional discrimination can hinder women's access to maternal health services and have recommended that states put a particular focus on the maternal health needs of women who face discrimination in health care access, including adolescents, poor women, minority women, rural women, migrant women, and women with disabilities. This requires the collection of disaggregated data on maternal mortality.[53]

In the first decision by a treaty monitoring body on maternal mortality, *Alyne da Silva Pimentel v. Brazil*, the CEDAW Committee found that Brazil had discriminated against Alyne, an Afro-Brazilian woman who died from obstetric complications after being denied quality maternal health care in both private and public health care facilities. The Committee recognized that Alyne experienced discrimination on the basis of her sex, her status as a woman of African descent and her socioeconomic background.[54] However, the CEDAW Committee's general recommendations to Brazil failed to address the State's obligation to

---

[48] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981).
[49] CEDAW Committee, *Gen. Recommendation No. 24*, para. 31(e).
[50] CESCR Committee, *Gen. Comment No. 14*, para. 12; CEDAW Committee, *Gen. Recommendation No. 24*, paras. 26, 27; CESCR Committee, *Gen. Comment No. 22*, para. 45.
[51] CESCR Committee, *Gen. Comment No. 22*, paras.7-8; Human Rights Committee, *Gen. Comment No. 36*, para. 26; CESCR Committee, *Gen. Comment No. 14*, paras. 4, 10 – 12; CRC Committee, *Gen. Comment No. 20*, para.57; CRC Committee, *Gen. Comment No. 15*, paras. 5, 13, 17.
[52] Human Rights Committee, *Gen. Comment No. 36*, para. 26. *See also* Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Reducing maternal mortality: the contribution of the right to health*, paras. 31-36, U.N. Doc. A/61/338 (2006).
[53] CESCR Committee, *Gen. Comment No. 14,* para. 20; CESCR Committee, *Gen. Comment No. 20*, para. 20; CEDAW Committee, *Gen. Recommendation No. 9*; CRC Committee, *General Comment No. 5*, para. 45; CRC Committee, *Gen. Comment No. 20*, para. 37(c); CEDAW Committee, *Concluding Observations: Romania*, paras. 40-41, U.N. Doc. CEDAW/C/ROU/CO/7-8 (2017); CEDAW Committee, *Concluding Observations: Lesotho*, paras. 32-33, U.N. Doc. CEDAW/C/LSO/ CO/1-4/Add.1 (2013). *See also* Special Rapporteur on violence against women, its causes and consequences, *A human-rights based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, paras. 43-44, 81(t), U.N. Doc. A/74/137 (2019) (The Special Rapporteur on violence against women has also recognized the "aggravating negative impact" of intersectional discrimination in maternal health care, noting, among other examples, the discriminatory practice of segregating women within maternal health facilities based on race or ethnicity, and stating that "appropriate legal and policy responses are needed in this regard."); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Reducing maternal mortality: the contribution of the right to health*, para. 17(c), U.N. Doc. A/61/338 (2006) (…this entails services that are "sensitive to gender and to the rights and cultures of minorities and indigenous peoples" and "may require addressing discriminatory laws, polices, practices and gender inequalities that prevent women and adolescents from seeking good quality services.").
[54] Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, para. 7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

specifically prohibit and prevent the intersectional discrimination, based on race and sex, that contributed to Alyne's death.[55]

1. South Asia

As COVID-19 spread in Pakistan, freedom of movement was restricted through a national lockdown, and with health care facilities overburdened, priority of services and resources rapidly shifted to the pandemic and away from SRH care.[56] While Pakistan had among the highest maternal deaths in the region and faced significant lack of access to antenatal care, emergency obstetric and neonatal care, and trained birth attendants before COVID-19, it had made some gains.[57] Not only did the pandemic itself exacerbate these problems but so did the government's policies that largely neglected essential maternal health needs when shifting priority care and resources almost exclusively to COVID-19. Entirely closing public transport in certain heavily populated areas and other lockdown restrictions, women were more likely to experience delays in reaching hospitals during emergencies, and to accommodate these additional emergency needs, hospitals had to equip and rely on skilled midwives to deliver safely in communities instead.[58] Health care providers instead emphasized home care deliveries despite the government's focus on promoting pre-natal screening, hospital-based deliveries if necessary, and greater investments in emergency obstetric services in the years before the pandemic.[59] Suddenly relying on trained midwives during the pandemic to meet the needs of pregnant women, there was a dearth of proper resources—including of protective equipment to deliver babies in home settings without spreading COVID-19.[60]

After a year into COVID-19, other countries in the region faced similar challenges. In Bangladesh, COVID-19 led to a 50% decrease in maternal and child health service uptake.[61] In Nepal, institutional births reduced by over half during its national lockdown, with over twice the number of maternal deaths typically recorded in Nepal in the first two months of Nepal's lockdown.[62] Lockdowns have also restricted the supply of misoprostol in Nepal, a lifesaving treatment of postpartum hemorrhage and medical abortion.[63] And, more generally, according to a UNICEF report in 2021 the direct and indirect effects of COVID-19 and its response in South Asia may have contributed between 2021-2022 to an increase in adolescent pregnancies of 405,640, 655 maternal and 9,986 neonatal deaths, 154,985 low birthweight births, 29,000 children

---

[55] *Id.* para 8.
[56] Collective for Social Science Research & Center for Reproductive Rights, *Impact of COVID-19 on Sexual and Reproductive Health and Rights in Sindh*, November 10, 2020, p. 6, https://reproductiverights.org/impact-of-covid-19-on-reproductive-health-and-rights-in-sindh/.
[57] *Id.*, p. 13.
[58] *Id.*, p. 14.
[59] *Id.*, p. 15.
[60] *Id.*, p. 15.
[61] UNICEF Bangladesh, *Building back better: Saving vulnerable newborns with revitalized health services*, April 1, 2021, https://www.unicef.org/bangladesh/en/stories/building-back-better-saving-vulnerable-newborns-revitalized-health-services.
[62] Amnesty International, *Nepal: "Struggling to breathe": The second wave of Covid-19 in Nepal*, June 14, 2021, p. 2-3, https://www.amnesty.org/en/documents/asa31/4229/2021/en/; Arijen Poudel, Amid focus on Covid-19, pregnant women at risk of not getting care, May 19, 2021, THE KATHMANDU POST, https://kathmandupost.com/health/2021/05/19/amid-focus-on-covid-19-pregnant-women-at-risk-of-not-getting-care.
[63] Marty Logan, *Lockdown in Nepal further strains supply of lifesaving maternal health drug*, BRITISH MEDICAL JOURNAL, June 22, 2021, p. 1-2, https://doi.org/10.1136/bmj.n1569.

stunted by the age of 2, child mortality could (or may already have) increase by 18–40%, and maternal mortality by 14–52% in the region.[64]

2. United States

In the U.S., Black and Indigenous women face a maternal health crisis, with significantly higher rates of maternal mortality[65] and pregnancy complications[66] than white women. In hospital settings, where most Black women in the United States give birth, racism and sexism facilitate mistreatment and abuse.[67] In addition, pregnant people across the U.S. have been subjected to criminal prosecution or other punitive legal systems because of their pregnancy or an outcome of their pregnancy.[68] This punishment disproportionately affects BIPOC and immigrant women, especially those living in poverty. As medical and public health experts have cautioned,[69] the threat of criminal or civil punishment harms the health of pregnant people by eroding trust in the medical system and deterring them from care when they most need it. This only compounds the existing health risks faced by Black and Indigenous birthing people.[70]

Disproportionate, intersectional impacts in maternal health care during COVID-19 were particularly evident in the United States. As COVID-19 rapidly spread and shutdowns implemented, generations of racial divisions and institutional discrimination were also in the spotlight in the aftermath of George Floyd's murder in the custody of a white police officer. COVID-19's disproportionate effects on maternal health in the United States were also apparent in divisions among ethnicity, class, indigenous groups, and of other persons of diverse SOGIESC. Indeed, the same structural, institutional, and interpersonal racism that drives disparate maternal health outcomes has also been at the root of inequitable COVID-19 outcomes.

---

[64] UNICEF South Asia, Direct and indirect effects of COVID-19 pandemic and response in South Asia, March 2021, p. 8, 28, https://www.unicef.org/rosa/media/13066/file/Main%20Report.pdf. The report specifically examined and collected data from Afghanistan, Bangladesh, Nepal, India, Pakistan and Sri Lanka.

[65] Emily Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016*, CDC (Sept. 6, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm; Emily Peterson et al., *Morbidity and Mortality Weekly Report, Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, CDC (May 10, 2019), https://pubmed.ncbi.nlm.nih.gov/31071074/.

[66] Andrea Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, AJOG (Dec. 2, 2013), https://www.ajog.org/article/S0002-9378(13)02153-4/fulltext.

[67] Center for Reproductive Rights & Black Mamas Matter Alliance, *Submission to the UN Special Rapporteur on Violence against Women* (May 17, 2019), https://www.reproductiverights.org/sites/default/files/2019-07/SR%20VAW%20joint%20submission_CRR%2BBMMA_May%202019_FINAL.pdf.

[68] *See e.g.*, Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y, & L. 299 (Apr. 2013), https://read.dukeupress.edu/jhppl/article/38/2/299/13533/Arrests-of-and-Forced-Interventions-on-Pregnant; If/When/How: Lawyering for Reproductive Justice, *Roe's Unfinished Promise: Decriminalizing Abortion Once and For All* (2019), https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/; Wendy Bach, *Prosecuting Poverty, Criminalizing Care*, 60 WM. & MARY L. REV. 809 (2019), https://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=3789&context=wmlr.

[69] *See e.g.*, ACOG, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period: Statement of Policy* (2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.

[70] *For more on these issues, see* Center for Reproductive Rights and partner reproductive rights and justice organizations' submission: *Suggested List of Themes to the Country Rapporteur and Task Force on the United States for the 106th Session of the Committee on the Elimination of Racial Discrimination, April 11-29, 2022*, available at https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/INT_CERD_NGO_USA_48581_E.pdf.

Black and Latinx people in the United States are three times more likely than white people to become infected with COVID-19 and twice as likely to die from it.[71] Both groups are also significantly overrepresented among pregnant people with COVID-19.[72] "Essential workers", who generally have few labor protections during the pandemic, are more likely to be women, people of color, and immigrants.[73] Essential workers are more exposed to infection and, particularly at the outset of the pandemic, have less access to testing and effective treatment.[74] Yet, for women and mothers of color, COVID-19's impacts are intensified by societal expectations that they take on caregiving roles and other "essential" work.

Economic barriers to access, resulting in significant class disparities in health outcomes, is among the highest barriers to maternal care in the United States, made even more challenging during the pandemic. In the first four months of the pandemic in the United States, over five million people became uninsured due to job losses.[75] Financial barriers in states where public assistance in obtaining health insurance coverage is especially limited, with hospitals closing and consequentially disproportionately harming rural communities and communities of color.[76] As COVID-19 exerted an unprecedented financial challenge for hospitals, some hospitals having stopped delivering babies while they cope with COVID-19.[77] The American health care system ensure that essential health services are available nationwide.

3. Peru

In Peru, indigenous women have historically experienced serious violations of their sexual and reproductive rights, including being subjected to obstetric violence during childbirth. For example, when Eulogia,[78] a *campesino* woman descendant from the original Quechua people of Peru, went into labor, instead of respecting her decision to have a homebirth (as she had done with her other five children), she was forced by local health authorities to go to a health center, under the threat of both a monetary fine and the withholding of the birth certificate of her child. Once at the health center, Eulogia was not provided with assistance in her language, Quechua, and was violently and physically forced by a nurse to give birth in a

---

[71] Richard Oppel Jr. et. al., *The Fullest Look Yet at the Racial Inequity of Coronavirus*, THE NEW YORK TIMES, July 5, 2020, https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?referringSource=articleShare; *see also* Centers for Disease Control and Prevention, *Working Together to Reduce Black Maternal Mortality*, April 6, 2022, https://www.cdc.gov/healthequity/features/maternal-mortality/index.html (highlighting the disparities in maternal mortality among black and white women in the United States).
[72] Richard Oppel Jr. et. al., *The Fullest Look Yet at the Racial Inequity of Coronavirus*, THE NEW YORK TIMES, July 5, 2020, https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?referringSource=articleShare.
[73] Campbell Robertson and Robert Gebeloff, *How Millions of Women Became the Most Essential Workers in America*, THE NEW YORK TIMES, September 22, 2021, https://www.nytimes.com/2020/04/18/us/coronavirus-women-essential-workers.html.
[74] *Id.*
[75] Stan Dorn, *The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History*, Families USA, July 13, 2020, https://www.familiesusa.org/resources/the-covid-19-pandemic-and-resulting-economic-crash-have-caused-the-greatest-health-insurance-losses-in-american-history/ (also cited in THE NEW YORK TIMES, *A Record 5.4 Million Americans Have Lost Health Insurance, Study Finds*, July 16, 2020, https://www.nytimes.com/2020/07/13/world/coronavirus-updates.html).
[76] Kirk Siegler, *Small-Town Hospitals Are Closing Just As Coronavirus Arrives In Rural America*, National Public Radio, April 9, 2020, https://www.npr.org/2020/04/09/829753752/small-town-hospitals-are-closing-just-as-coronavirus-arrives-in-rural-america.
[77] Eileen Guo, Coronavirus Threatens an Already Strained Maternal Health System, THE NEW YORK TIMES, March 26, 2020, https://www.nytimes.com/2020/03/26/us/coronavirus-pregnancy-maternal-health-system.html.
[78] Eulogia and her son Sergio's case are currently before the Inter-American Commission on Human Rights' merits stage. The Admissibility Report was issued on April 4, 2014. See, Admissibility Report, No. 35/14, Petition No. 1334-09, April 4, 2014, OEA/Ser.L/V/II.150, http://www.oas.org/es/cidh/decisiones/2014/PEAD1334-09ES.pdf.

horizontal position against her ancestral customs. During this struggle, her son, Sergio, was born and his head hit the ground. In the immediate aftermath, Eulogia was not only denied information regarding her son's health status but was also forced to shower with cold water against her own will and against her people's cosmovision that considers cold water as a wound to the body that has just given birth. As a result of the injury Sergio suffered at birth, he had multiple severe health problems and ultimately died at the age of 12.[79]

Eulogia's case reveals a system of institutionalized gender-based violence that perpetuates discriminatory stereotypes against indigenous peoples—in particular, indigenous women, and *campesino*, Quechua-speaking and poor women. Fueled by negative stereotypes about indigenous customs regarding pregnancy, childbirth and postpartum as "backward" and "ignorant,"[80] this violence also illustrates the impact of intersectional discrimination on the provision of care during childbirth.[81]

IV. Abortion during COVID-19

Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality[82] and found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[83] In General Comment No. 36 on the right to life, the Human Rights Committee has specified that states should not regulate pregnancy or abortion in ways that force women and girls to resort to unsafe abortions, and they should revise their abortion laws accordingly, including by refraining from introducing new barriers to abortion (non-retrogression principle).[84] Moreover, the CEDAW Committee has found that criminalization of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy are forms of gender discrimination and gender-based violence.[85]

---

[79] PROMSEX. *Eulogia, Hechos del Caso*, https://incidenciainternacional.promsex.org/2020/06/23/eulogia/.
[80] Center for Reproductive Rights and PROMSEX, *Case of Eulogia Guzmán and her son Sergio v. Perú*, p.4 (2022).
[81] Gita Sen, Bhavya Reddy & Aditi Iyer, *Beyond measurement: the drivers of disrespect and abuse in obstetric care*, Reproductive Health Matters, 26:53, 6-18 (2018) (noting, "The care provided to indigenous people who are often at the lower ends of social and economic hierarchies tends to be non-evidence-based, risky and even harmful . . . It is also often rife with cultural bias and insensitivity, making the experience of childbirth physically and emotionally traumatic by forcing indigenous women who are used to delivering in squatting or other positions to deliver lying down, not allowing companionship, or insisting on unauthorised discharge of the placenta, which can carry deep cultural and spiritual significance.").

[82] CESCR Committee, *Gen. Comment No. 22*, paras. 10, 28; Human Rights Committee, *Gen. Comment No. 36*, para. 8. *See also*, Human Rights Committee, *Concluding Observations: Nigeria,* para. 22, U.N. Doc. CCPR/C/NGA/CO/2 (2019); CEDAW Committee, *Concluding Observations: Paraguay*, paras. 30, 31, U.N. Doc. CEDAW/C/ PRY/CO/6 (2011); CEDAW Committee, *Concluding Observations: Sierra Leone,* para. 32(d), U.N. Doc. CEDAW/C/SLE/CO/6 (2014)*;* CESCR Committee, *Concluding Observations: Argentina,* para. 55, 56, U.N. Doc. E/C.12/ARG/CO/4 (2018).
[83] Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, paras. 7.6, 7.7, 7.8, U.N. Doc. CCPR/C/116/D/2324/2013 (2016); Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, paras. 7.7 - 7.9, 7.12, U.N. Doc. CCPR/C/119/D/2425/2014 (2017); K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/ C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); CESCR Committee, Gen. Comment No. 22, para. 10.; Alyne da Silva Pimentel Teixeira v. Brazil, CEDAW Committee, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011); CAT Committee, *Concluding Observations: El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); CAT Committee, *Concluding Observations*: *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
[84] Human Rights Committee, *Gen. Comment No. 36*, para. 8.
[85] CEDAW Committee, *Gen. Recommendation No. 35,* para. 18.; CEDAW Committee, *Gen. Recommendation No. 24,* paras. 11, 14.

Treaty monitoring bodies recommend that states should decriminalize abortion[86] and liberalize their abortion laws to improve access; they should also remove legal, financial, and practical barriers that deny effective access by women and girls to safe and legal abortion,[87] including medically unnecessary barriers to abortion and third-party authorization requirements.[88]

In outlining states' core obligations to ensure the satisfaction of minimum essential levels of the right to sexual and reproductive health, the CESCR Committee notes that states "should be guided by . . . the most current international guidelines established by United Nations agencies, in particular WHO.[89] In its most recent Abortion Care Guideline, the World Health Organization (WHO) recommends the full decriminalization of abortion[90] and against laws and other regulations that restrict abortion by grounds. The WHO recommends that abortion be available on the request of the woman, girl or other pregnant person.[91] It further recommends against gestational age limits,[92] mandatory waiting periods for abortion[93] and third-party authorization.[94]

The WHO's Abortion Care Guideline provides public health evidence to support its law and policy recommendations and consistently refers to discrimination, including based on race and ethnicity, as playing a part in hindering access to abortion services.[95] For example, the WHO found that evidence showed that third-party authorization requirements delayed access to abortion for minors, with a disproportionate impact on "minors from ethnic minorities or of lower socioeconomic status."[96]

---

[86] *See, for example*, Human Rights Committee, *Gen. Comment No. 36*, para. 8; CEDAW Committee, *Gen. Recommendation No. 24*, para. 14; CESCR Committee, *Gen. Comment No. 22*, paras. 34, 40, 49(a), 57; Human Rights Committee, *Concluding Observations: Argentina*, para. 12, U.N. Doc. CCPR/C/ARG/CO/5 (2016); Committee on the Elimination of Discrimination against Women, *United Kingdom of Great Britain and Northern Ireland Inquiry Summary (Article 8 of Optional Protocol to Convention on the Elimination of All Forms of Discrimination against Women)*, para. 58, U.N. Doc. CEDAW/C/OP.8/GBR/1 (2018); Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against Women, *Joint Statement: Guaranteeing sexual and reproductive health and rights for all women in particular women with disabilities*, available at https://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx (29 August 2018).

[87] Human Rights Committee, *Gen. Comment No. 36*, para. 8; Human Rights Committee, *Gen. Comment No. 28*, paras. 10-11; CESCR Committee, *Gen. Comment No. 22*, paras. 28, 34, 40, 41, 45, 49(a), 49(e), 57; CEDAW Committee, *Gen. Recommendation No. 24*, para. 14; CEDAW Committee, *Gen. Recommendation No. 35*, para. 29(c)(i); CEDAW Committee, *Gen. Recommendation No. 34*, para. 39(c); CRC Committee, *Gen. Comment No. 20*, para. 60, U.N. Doc. CRC/C/GC/20 (2016); CRC Committee, *Gen. Comment No. 15*, paras. 31, 70, U.N. Doc. CRC/C/GC/15 (2013); Human Rights Committee, *Concluding Observations: Angola*, paras. 21-22, U.N. Doc. CCPR/C/AGO/CO/2 (2019); CESCR Committee, *Concluding Observations: Cameroon*, para. 59, U.N. Doc. E/C.12/CMR/CO/4 (2019); CEDAW Committee, *Concluding Observations: Colombia*, paras. 37-38, U.N. Doc. CEDAW/C/COL/CO/R.9 (2019); CRC Committee, *Concluding Observations: Bahrain*, para. 38, U.N. Doc. CRC/C/BHR/CO/4-6 (2019).

[88] Human Rights Committee, *Gen. Comment No. 36*, para. 8; CESCR Committee, *Gen. Comment No. 22*, para. 41; CEDAW Committee, *Gen. Recommendation No. 24*, para. 14.

[89] CESCR Committee, *Gen. Comment No. 22*, para. 49.

[90] World Health Organization, Abortion Care Guideline (2022), Section 2.2.1 (pp. 24–25), https://www.who.int/publications/i/item/9789240039483.

[91] *Id.* at Section 2.2.2 (pp. 26–27).

[92] *Id.* at Section 2.2.3 (pp. 28–29).

[93] *Id.* at Section 3.3.1 (pp. 41–42).

[94] *Id.* at Section 3.3.2 (pp. 42–44).

[95] Id. at p. 42.

[96] Id. at p. 43.

Timely abortion access is essential to preserve the life and health of pregnant people.[97] COVID-19 has threatened such essential care by, among other things, disrupting regular supply chains and logistics networks, causing delays at all levels in supply production and manufacturing, impacting and disrupting the availability of lifesaving SRH supplies, and consequentially, yielding disproportionately heavy impacts on developing regions that rely on large-scale international procurement and global stockpiling of life-saving supplies.[98] Unintended pregnancies can threaten the lives or significantly impact the health of women and girls, and thus ensuring access to timely contraception is also essential to protect SRHR. Despite the essentiality of safe abortion (pre- and post) and contraception, specific barriers exacerbated during the COVID-19 include longer waiting periods and multiple provider authorization for abortion, prescriptions for contraceptives, restrictions on medication abortion, limited access to abortion based on certain grounds and refusing to provide for abortion on request, and parental consent requirements for access to SRH services.[99]

Concerningly, denial of access to essential SRH services such as safe abortion and contraception, intrapartum care for all births, emergency obstetric and newborn care, clinical care for rape survivors, and prevention and treatment for HIV and other sexually transmitted infections can lead to dramatically increased morbidity and mortality rates.[100] Risks of such denial or neglect amplifies during emergencies like COVID-19. Indeed, early estimates during the pandemic have indicated a 10% (viz. 3,325,000) global rise in unsafe abortions and 1,000 additional maternal deaths.[101] Additionally, a 10% decline in use of short- and long-acting reversible contraceptives could or may have already resulted in 15,401,000 additional unintended pregnancies.[102] These impacts are usually felt most acutely among disadvantaged and neglected groups, including victims of gender-based violence.[103]

V. Victims and survivors of gender-based violence (GBV) and human rights defenders

The duty to protect the right to life under the ICCPR requires State parties "to take special measures of protection towards persons in vulnerable situations whose lives have been placed at particular risk because of specific threats or pre-existing patterns of violence.[104] Such persons include those experiencing GBV and SRHR defenders.[105]

---

[97] *See* CESCR Committee, Gen. Comment No. 22, paras. 10, 28; Human Rights Committee, Gen. Comment No. 36, para. 8 (recognizing the connection between unsafe abortion and maternal mortality, and thus the need to ensure it under the right to life).
[98] *Id.*
[99] *See generally* Guttmacher Institute, *Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries*, April 2020, https://www.guttmacher.org/sites/default/files/article_files/4607320.pdf.
[100] The Inter-Agency Working Group on Reproductive Health in Crises, *COVID-19 Pandemic Further Threatens Women and Girls Already at Risk in Humanitarian and Fragile Settings*, May 2020, p. 3.
[101] Guttmacher Institute, *Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries*, April 2020, p. 75, https://www.guttmacher.org/sites/default/files/article_files/4607320.pdf.
[102] The Inter-Agency Working Group on Reproductive Health in Crises, *COVID-19 Pandemic Further Threatens Women and Girls Already at Risk in Humanitarian and Fragile Settings*, May 2020, p. 3.
[103] Guttmacher Institute, *Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries*, April 2020, p. 75, https://www.guttmacher.org/sites/default/files/article_files/4607320.pdf.
[104] Human Rights Committee, *Gen. comment No. 36: Article 6 (right to life)*, CCPR/C/GC/36, September 3, 2019, para. 23.
[105] *Id.*

Restrictive measures on the freedom of movement during COVID-19— e.g. lockdowns and stay-at-home orders— increased exposure to GBV. GBV includes, among other forms of violence, the denial or delay of safe abortion and postabortion care and forced continuation of pregnancy.[106] Compliance with the right to life and the special protections for persons experiencing GBV in emergency settings necessitate positive measures included in COVID-19 policies in order to ensure accessible and available means of safety such as the prioritization on services and safe shelters for victims, effective referral systems, an adequate supply of SRH resources, information and awareness campaigns, and effective access to justice and redress through the judicial system.[107] Implementing these positive measures should ensure women's equal representation, meaningful participation and leadership at all levels and recognize women as significant agents for societal change in the present and post COVID-19 period.[108] As lockdowns and other restrictions on freedom of movement heightened risks for GBV across the world, States must do more to inform service providers about the heightened risk of domestic violence, develop adequate responses such as hotlines or shelters to survivors and expand screenings and support for sexual violence against women and girls including for mental health to ensure compliance with the right to life.[109]

GBV increased across regions during the pandemic. In India, crimes against women rose by 7% in 2020, and after just two months in lockdown, domestic violence complaints rose by 131%.[110] In Vietnam, the number of calls about GBV received by the hotline for the Central Vietnam Women's Union increased by 50% during lockdowns.[111] In China, GBV cases have spiked and 90% of cases have been attributed to COVID-19 policies.[112] In Europe, no EU Member State had a gender-sensitive disaster plan in place to address a potential spike in GBV. Only when GBV inevitably spiked did 11 countries develop a national policy or action plan to address GBV, and "in only three countries did the plan or policy include specific measures to tackle the issues."[113] In South America, Peru reported nearly 16,500 cases of violence against women and girls between March and December; while calls into the country's emergency sexual violence hotline almost doubled in 2020 compared to 2019.[114] In Colombia, GBV levels rose more than half since the pandemic began.[115]

---

[106] Committee on the Elimination of Discrimination against Women, General Recommendation No. 30: Women in conflict prevention, conflict, and post-conflict situations, in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 18, U.N. Doc. CEDAW/C/GC/30 (2013) [CEDAW Committee, Gen. Recommendation No. 30]; CEDAW Committee, Gen. Recommendation No. 24, paras. 11, 14.

[107] Office of the UN High Commissioner for Human Rights, *COVID-19 Guidance*, https://www.ohchr.org/en/covid-19/covid-19-guidance; International Commission of Jurists, *The Courts and COVID-19*, April 6, 2020, p. 5, https://www.icj.org/wp-content/uploads/2020/04/Universal-ICJ-courts-covid-Advocacy-Analysis-brief-2020-ENG.pdf.

[108] CEDAW Committee, Guidance Note on CEDAW and COVID-19, para. 3 (2020), https://www.ohchr.org/en/hrbodies/cedaw/pages/cedawindex.aspx.

[109] World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context*, 2020, p. 31.

[110] INDIAN EXPRESS, *Locked In*, July 25, 2020, https://indianexpress.com/article/opinion/editorials/covid-19-pandemic-women-violence-un-6522082/.

[111] Phung Le Dung, *The Impacts of the Covid-19 on Vietnam's Workforce*, MODERN DIPLOMACY, April 3, 2021, https://moderndiplomacy.eu/2021/04/03/the-impacts-of-the-covid-19-on-vietnams-workforce/.

[112] Zhang Wanquing, *Domestic Violence Cases Surge During COVID-19 Epidemic*, SIXTH TONE, https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic.

[113] Europe Institute for Gender Equality, *EIGE-2021 Gender Equality Index 2021 Report: Health*, October 28, 2021, https://eige.europa.eu/publications/gender-equality-index-2021-health.

[114] Paula Dupraz-Dobias, Latin American women battle shadow pandemic of gender-based violence, THE NEW HUMANITARIAN, February 24, 2021, https://www.thenewhumanitarian.org/news-feature/2021/2/24/latin-american-women-battle-pandemic-gender-based-violence.

[115] *Id.*

SRHR defenders have also been targeted throughout the pandemic.[116] Using COVID-19 measures and vague references to public health needs as justifications, some countries have escalated threats against human rights defenders, often targeting those defending the right to abortion or expressing their sexual orientation.[117] For example, in Poland several women's rights defenders were detained or face criminal charges after peacefully protesting a ruling by the country's Constitutional Tribunal that virtually eliminated access to legal abortion. Among the bases for the charges was the creation of an "epidemiological threat" for protests held during the Covid-19 pandemic.[118] Clampdowns on human rights defenders was also a way to distract from poor pandemic responses by the government. In Uganda, COVID-19 was used at least twice between 2020-2021 as a pretext to arrest LGBTQ+ people on charges of "a negligent act likely to spread infection of disease."[119] And in Brazil, then President Jair Bolsonaro removed two public servants after they signed a technical note recommending that authorities maintain SRH services during the COVID-19 pandemic, including "safe abortion in the cases permitted by Brazilian law."[120]

VI. Emergency Measures and Legal Barriers to SRH Services

COVID-19 led many countries to issue states of emergency. The declaration of a state of emergency often grants additional authority by temporarily restricting or suspending certain constitutional rights, temporarily shifting authority from the legislature to the executive branch, and concentrating power in the central government instead of local authorities. Several countries erected legal barriers or other restrictions to safe abortion and other SRH services during COVID-19 under the guise of broad emergency orders.[121] In Brazil, only 42 hospitals (i.e. only one hospital for every five million Brazilians) were performing legal abortions during the pandemic after the Bolsonaro government refused to recognize SRH services as essential.[122] In the United States, many state governors through executive orders used COVID-19 as a pretext to restrict abortion access and deem other SRH services as non-essential.[123] *Migrants and Asylum Seekers*

Migrants and people seeking asylum are vulnerable to human rights violations based of their immigration status, gender, age, disability, sexual orientation, gender identity or expression, race, language, ethnicity, and other status. Pregnant migrants, refugees, and asylum seekers face additional risks of discrimination and adverse health outcomes. For example, despite already being a major driver of migration to the United

---

[116] Office of the UN High Commissioner for Human Rights, *Defenders of the human rights of LGBT persons constantly at risk, warn UN experts*, March 24, 2022, https://www.ohchr.org/en/statements/2022/03/defenders-human-rights-lgbt-persons-constantly-risk-warn-un-experts.

[117] Human Rights Watch, *The Right of Everyone to Sexual and Reproductive Health: Challenges and Opportunities During Covid-19: Submission by Human Rights Watch to the UN Special Rapporteur on the Right to Health*, June 10, 2021, https://www.hrw.org/news/2021/06/10/right-everyone-sexual-and-reproductive-health-challenges-and-opportunities-during.

[118] Human Rights Watch, *Poland: Escalating Threats to Women Activists*, March 31, 2021, https://www.hrw.org/news/2021/03/31/poland-escalating-threats-women-activists.

[119] Human Rights Watch, *The Right of Everyone to Sexual and Reproductive Health: Challenges and Opportunities During Covid-19: Submission by Human Rights Watch to the UN Special Rapporteur on the Right to Health*, June 10, 2021, https://www.hrw.org/news/2021/06/10/right-everyone-sexual-and-reproductive-health-challenges-and-opportunities-during.

[120] *Id.*

[121] *See* Report of the Working Group on discrimination against women and girls, *Women's and girls' sexual and reproductive health rights in crisis*, April 28, 2021, para. 53 (observing that "a number of countries" exploited COVID-19 to restrict access to SRH services).

[122] Human Rights Watch, Brazil: Protect Sexual, Reproductive Rights in Pandemic, June 12, 2020, https://www.hrw.org/news/2020/06/12/brazil-protect-sexual-reproductive-rights-pandemic.

[123] Laurel Sobel et. al., *State Action to Limit Abortion Access During the COVID-19 Pandemic*, Kaiser Family Foundation, August 10, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/; Caroline Kelly, Mississippi, Texas and Ohio move to limit abortion as part of coronavirus response, CNN, March 25, 2020, https://www.cnn.com/2020/03/25/politics/coronavirus-abortion-texas-ohio/index.html.

States before COVID-19, high rates of GBV in South America and Central America during COVID-19 lockdowns increased migration levels to the United States by 70%. Meanwhile, the American government exacerbated the plight of migrants and asylum seekers entering from Latin America amid COVID-19. As a party to the 1967 Protocol relating to the Status of Refugees, the United States is bound to the Refugee Convention and the non-refoulement principle. The United States is also a party to the ICCPR which requires states to provide protection for individuals who claim a risk of a violation to their right to life even if they are not entitled to refugee status.

Nonetheless, the United States exploited the COVID-19 crisis to violate their human rights obligations by blocking and expelling—first temporarily and then indefinitely—more than 109,000 migrants and people seeking asylum, including many unaccompanied children, either to Mexico or to their home countries.[124] A survey conducted by the International Office of Migration found that approximately 3.4% of migrant and asylum-seeking women in Ciudad Juárez alone, i.e. more than 200, were pregnant.[125] Forcing asylum seekers and migrants to wait in Mexico in dangerous and unsanitary conditions while awaiting immigration court hearings in the United States has risked the lives and health of pregnant women. Conditions of encampments where migrants and asylum seekers must wait are "unsafe, unsanitary, and inhumane," lacking access to basic needs such as potable water, nutritious food, sanitation, and prenatal or obstetric care, and face exposure to extreme weather conditions.[126] Quality maternal nutrition is necessary for the development of the fetus due to the increased need for specific vitamins and minerals during pregnancy, and lack of access to prenatal care and adequate nutrition increases the risk of pregnancy complications, preterm birth, low-birthweight infants, and stillbirths.[127] American policy has imperiled the lives of pregnant migrant and asylum seeking women, with reckless disregard for their maternal health rights.

VII. Good Practices

While COVID-19 unleashed an unprecedented crisis requiring emergency measures to address immediate public health needs, the magnitude of a crisis does not permit derogation from essential health services like SRH. As the examples above make clear, crises may in fact require greater positive measures to ensure quality SRH care and services in line with the rights to life and health. In order to do so, States should first ensure responses to COVID-19 fully consider and address specific and unique situations, perspectives and needs of women, girls, and LGBTI+ people by including them in decision-making roles, and that any measures taken do not directly or indirectly discriminate based on gender or any other disadvantaged

[124] Centers of Disease Control and Prevention, *Order Suspending Introduction of Certain Persons From Countries Where a Communicable Disease Exists* (42 U.S.C. §§ 265, 268), March 20, 2020, https://www.cdc.gov/quarantine/pdf/CDC-Order-Prohibiting-Introduction-of-Persons_Final_3-20-20_3-p.pdf.
[125] International Office of Migration, *Población bajo los Protocolos de Protección a Migrantes en Ciudad Juárez 2020*, 2020, p. 5.
[126] *See generally* Human Rights First, *Human Rights Travesty: Biden Administration Embrace of Trump Asylum Expulsion Policy Endangers Lives, Wreaks Havoc*, September 2021, https://humanrightsfirst.org/wp-content/uploads/2021/10/HumanRightsTravesty_FINAL-1.pdf; *see also* Physicians for Human Rights, *"Unsafe, Unsanitary, Inhumane": PHR Medical Expert's Observations at the Matamoros Migrant Encampment*, September 26, 2019, https://phr.org/news/phr-statement-on-migrant-protection-protocols/;
[127] Center for Reproductive Rights, *Joint Report: Pregnant Immigrants and Asylum Seekers During COVID-19*, September 14, 2020, p. 6.

group.[128] More specific services towards best practices in the provision of essential SRH care are outlined below.

In line with the WHO's recommendations during COVID-19, States should make universally accessible and available digital health services, self-care interventions, task sharing and outreach to ensure access to medicines (including contraceptives), diagnostics, devices, information and counselling.[129] Considering supply chain bottlenecks in SRH supplies and resources, States should also enable pharmacies and drugstores to increase the range of contraceptive options.[130] Implementation of telemedicine services and virtual or phone services and permitting self-administration of contraceptive injections and medical abortions at home have also become effective practices to maintain access to SRH services during the pandemic.[131] The International Federation of Gynecology and Obstetrics, among the leading medical authorities worldwide on evidence-based practices in ensuring access to quality SRH, has recognized that abortion services should be permanently available via telemedicine and is especially important for disadvantaged groups.[132]

Indeed, many countries have implemented telemedicine or telecommunications to support SRH care and services during the pandemic. For example, 12 of 15 African countries that classified SRH as essential during the pandemic reported implementation of self-care interventions for contraception or safe abortion, with self-administered contraceptive injections being the most common.[133] In South America, Argentina has intensified the distribution of information about contraceptives and family planning through toll-free services.[134] Mexico has implemented ambulatory or self-managed services to guarantee access to abortion care and follow-up procedures through mobile phones.[135] Colombia has also been providing medical consultations, including for SRH services, through telemedicine or in the patients' house if possible and needed.[136]

VIII. Recommendations

---

[128] *See* UNICEF, *Protect the Promise: 2022 Progress Report on the Every Woman, Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016-2030),* 2022, p. 21 ("Mounting evidence shows that women's empowerment is directly related to improvements in maternal and child survival, increased coverage of maternal and child health interventions, improvements in early childhood development, and the creation of more equitable and peaceful societies.").

[129] World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context*, 2020, p. 29-30.

[130] *Id.*, p. 30.

[131] Center for Reproductive Rights, *Guaranteeing Access to Sexual and Reproductive Health Services during the COVID-19 Pandemic and Beyond*, June 8, 2021, p. 2, https://reproductiverights.org/sustaining-positive-measures-to-ensure-access-to-srh-services-during-the-covid-pandemic-and-beyond/.

[132] International Federation of Gynecology and Obstetrics, *FIGO endorses the permanent adoption of telemedicine abortion services,* March 26, 2021, https://www.figo.org/news/figo-endorses-permanent-adoption-telemedicine-abortion-services.

[133] World Health Organization, *Sexual and Reproductive Health and Rights in the context of COVID-19 in the African Region: rapid assessment of continuity of services*, September 2020, https://www.afro.who.int/publications/sexual-and-reproductive-health-and-rights-newsletter-first-issue-september-2020-0.

[134] Center for Reproductive Rights, *Guaranteeing Access to Sexual and Reproductive Health Services during the COVID-19 Pandemic and Beyond*, June 8, 2021, p. 3, https://reproductiverights.org/sustaining-positive-measures-to-ensure-access-to-srh-services-during-the-covid-pandemic-and-beyond/.

[135] *Id.*

[136] *Id.*

In line with the central issues raised above, we respectfully recommend key elements for OHCHR's upcoming follow-up report:

a. We recommend OHCHR urge States to decriminalize and make essential safe abortion services during emergencies, guarantee access to abortion with no restriction as to reason, and guarantee access to medication abortion and remove restrictions on telemedicine and self-managed medication abortion in order to remain compliant with the rights to life and health;

b. We also recommend OHCHR reiterate the essential nature of SRH care, services, and information during emergencies aligned with best practices outlined by the WHO and other international organizations, including on how States can overcome new barriers and limitations;

c. We further recommend the report address the need for States to refrain from suspending or revoking any proactive measures that have increased access to SRH health services and incorporate them into permanent public health policies and protocols;

d. Concurrently, we recommend the report address the abuse and exploitation of emergency measures to restrict SRH rights, including of marginalized and disadvantaged groups at heightened risk, and by limiting the expression rights of SRHR defenders;

e. Finally, we recommend the report recognize as necessary the incorporation of the unique knowledge, perspectives, and experiences women and other persons of diverse SOGIESC to effectively formulate essential health policies and to establish protocols to ensure continued access to effective and transparent remedies and redress for violations of the right to SRHR.

For any questions or further information, please contact Paola Salwan Daher, Associate Director for Global Advocacy at pdaher@reprorights.org.